

PATIENT INFORMATION RECORD



Physician _____ DATE _____ CHART _____

Referred By: _____

Reason for Today's Visit: _____

Last Name: _____ First: _____ Middle Initial + Suffix _____

Sex: Female Male Previous Last Name _____ Age _____ Date of Birth ____/____/____ Race _____

SSN: _____ Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____ Usual Physician: _____

Patient Status: (circle all that apply) Married Single Divorced Widow Homebound Retired Disabled Student

Type of Injury: Work Auto Sports Other _____ Injury Date _____
(For Injuries at Work – Please Complete Additional Paperwork. We will not file Motor Vehicle Insurance)

How Did You Hear About Us: Primary Doctor – ER – Friend – Web Site – Another Patient – Insurance Directory
(Please circle all that apply) School Contact – Hospital – LPGA – Yellow Page Ads – Other _____

Guardian Last Name: _____ First: _____ Middle Initial + Suffix _____

Emergency Contact Name: _____ Phone: (____) _____ Relationship _____
(Not living in same household)

Employer/School _____ Full Time Part Time Retired Student

Employer/School Address: _____ Phone (____) _____

Guarantor/Insured's Last Name: _____ First: _____ Middle Initial + Suffix _____

Guarantor Address if Different From Patient: _____

Zip Code: _____ City: _____ State: _____

SSN: _____ Date of Birth: ____/____/____ Employer: _____

Employer Address: _____ Phone: (____) _____

Insurance Information-Primary Insurance Company Name _____

Is this a group policy through your employer: Yes ___ No ___ Group Number: _____

Insured's Name: _____ Date of Birth ____/____/____ SS# _____

Insurance ID Number/Contract Number: _____ Date: _____

Patient's relationship to insured: _____ Office Visit Co-pay: \$ _____

Will you be paying co-pays and deductibles by: Cash ___ Check ___ Credit Card ___ (MC, VISA, AMEX, DISC)

Insurance Information-Second (#2) Insurance Company Name _____

Is this a group policy through your employer: Yes ___ No ___ Group Number: _____

Insured's Name: _____ Date of Birth ____/____/____ SS# _____

Insurance ID Number/Contract Number: _____ Effective Date: _____

Patient's relationship to insured: _____ Office Visit Co-pay: \$ _____

Will you be paying co-pays and deductibles by: Cash ___ Check ___ Credit Card ___ (MC, VISA, AMEX, DISC)

I have been shown a copy of Southern Orthopaedic Specialists, LLC (SOS) Privacy Notice and have been provided with a Patient Consent Form for treatment. The financial/credit policy of SOS has been provided to me and I agree to the terms as stated in that policy. I hereby assign to SOS all benefits payable under the terms of my insurance policy listed above. I realize that I am responsible for any balance not payable by my insurance company. I also understand that I will be responsible for any expenses incurred in the collection of outstanding balances that I may have, whether it be from a collection agency or an attorney.

Signature of Patient or Guardian _____ Date _____